"I've been crying my way"—qualitative analysis of a group of female patients' consultation experiences
Eva E Johansson, Katarina Hamberg, Gerd Lindgren* and Göran Westman


Background and objectives. What do women patients, sick-listed for biomedically undefined musculoskeletal disorders, expect and experience when they consult a doctor? With the purpose to learn more about this, a qualitative interview study was conducted.

Methods. Twenty women participated. They were patients at an urban health care centre in northern Sweden. Data were gained through repeated, semi-structured interviews, and analysed according to grounded theory.

Results. The participants described an atmosphere of distrust in the consultation. They had felt ignored, disregarded and rejected by doctors, and had worked out strategies to keep up medical attention in their search for a creditable diagnosis. They were somatizing, claiming under cover, and pleading, to catch the doctor's interest. In addition, they upheld their self-respect by mystifying and martyring themselves and their symptoms, and by condemning physicians as ignorant.

Discussion. The patient's consultation experiences are discussed from different aspects; the biomedical framework, the power asymmetry, and the gendered positions of patient and doctor. The findings indicate the importance of making doctors aware of the context behind frustrations in doctor–patient interaction.

Keywords. Consultation, gender, musculoskeletal pain, undefined disorders, women's health.

Introduction
Recent research has focused on the consultation and how to make it optimal. According to Pendleton, the desired outcome of a consultation is mutual understanding of the problem. To achieve this, a patient-centred approach is required, emphasizing the patient's life situation, expectations and feelings.

Despite aspirations of mutual understanding, we have ourselves, as family physicians (EJ, KH, GW), experienced consultations which leave us with a feeling of failure and frustration. These consultations have often concerned women patients with diffuse pain and musculoskeletal disorders (MSD), a major ill-health problem in many industrial countries. Dealing with patients with MSD, and especially patients with symptoms that fall outside the scope of a clear-cut physical pathology, is a task for the GP. Doctors' 'heart-sink' experiences of difficult consultations are documented, but what about the experiences of the patients themselves?

We conducted a qualitative interview study with the broad aim of learning more about female patients with MSD. This paper presents one part of that study, namely the analysis of the participants' consultation experiences: what they expected, experienced, and how they acted when they consulted doctors.

Methods
A qualitative approach was chosen as it is particularly suited to explore complex phenomena or topics that are poorly understood, such as awkward consultations and the experiences of patients.

Setting and participants
The participants were recruited at an urban community health care centre in Umeå, in northern Sweden, where two of the authors (EJ, KH) worked as family physicians. To be eligible for recruitment, the women had to consult for MSD, and be sick-listed for the same reason. The complaints were to have been medically investigated in primary as well as secondary care,
without finding any clear-cut medical or psychiatric diagnosis which could explain the pathogenesis. Women with a diagnosis of fibromyalgia were included, as the cause of that syndrome is still unknown, and effective treatment is lacking.\textsuperscript{11}

A strategic selection was used aiming at diversity regarding age, duration of pain and family situation. Participation was voluntary. Twenty-two women were invited, two refused. The participants were all born in Sweden, and between 21 and 60 years of age. They were or had been living in marital relationships, and 19 of them had children. All had finished compulsory school (6–9 years of schooling, starting at the age of 7), but few had any further secondary or vocational education. Everyone had a job when the study started, mainly physically demanding, low-paid work, such as cleaner, waitress or childminder. Most of the participants were frequent attenders of medical care, i.e., they had seen many doctors at different clinics during the last few years. They were sick-listed, long-term or repeatedly. The duration of the latest sick-listing period varied from 2 months to 4 years.

**Data collection**

Data were collected by repeated, semi-structured interviews conducted by one of the researchers (EJ or KH).\textsuperscript{10} Each interview lasted 1–2 hours, and was taped and transcribed. The aim of the interviews was to give the participant considerable control, and let her explain her situation in her own words. The interviewer tried to ease the narrative flow by probing questions like “Can you tell me . . .?”, “Would you give an example of that?” The only guideline was to cover broad topics; health history and experiences of health care, working and family life. All participants were interviewed on three occasions over 2 years, except one who was interviewed only twice due to practical circumstances, and one who withdrew after the first interview. The first interviews were conducted at the health centre, the later ones at the centre or in the patient’s home.

**Data analysis**

Collection of data, transcribing and preliminary analysis went on simultaneously. The data analysis was based on grounded theory.\textsuperscript{12} The researchers (EJ, KH) first examined and coded the transcripts independently. The codes were then compared, scrutinized, discussed and categorized. For the purpose of this paper, interview segments concerning “medical encounters” were systematically explored. Finally, all four researchers (EJ, KH, GL, GW) examined the codes and concepts, and how they were integrated.

**Results**

The women in the study presented ample experiences of utilizing medical service. Seeking help for chronic or recurrent problems, still undefined after several investigations, made them feel disappointed and frustrated in the medical setting.

**Experiences of distrust**

The participants all gave examples of distrust in the consultation; they felt themselves distrusted, and experienced a lack of faith in the doctors themselves. They said they “wanted a diagnosis”, and if no somatic pathology was found, they feared being classified as mentally ill, or dismissed as malingering and troublesome.

They described a vulnerable position. As patients they were subject to the doctor’s ability to define the illness and decisions over treatment measures such as prescriptions, referrals and certificates. If they took part in the medical dialogue, suggested a diagnosis or demanded further, more advanced examinations, the doctor might turn hostile. The women expressed how they felt ignored (1), disregarded (2) and rejected (3).

“When the doctor arrived, he had a ready-made diagnosis and didn’t listen to what I said” [1]. I talked to him about my back pain and how I perceive that the trouble in my feet and legs is connected with the spine. He said that was pure rubbish [2]. I found him brusque and unkind. And I was frightened and worried. He wanted to give me psychic drugs, antidepressants. I said I didn’t want that. He sat down to write a prescription without further explanation [2]. I asked for sleeping pills, but he refused [2,3]. He prescribed vitamin B and something else he didn’t explain [2], then he left. I felt that I’m not welcome [3] in the health care system. I used to think I should wear a little tinkle bell like those infected with the plague long ago in the past. I could jingle the bell to give them all a chance to run away, all of them.”

**Expectations of a ‘credible consultation’**

The women did not clearly depict their expectations of the consultation beyond wanting to ‘get help’ or ‘get well’. Distress was, however, spelled out concerning the taking of their respective medical histories, examination, communication and contact.
Three unspoken, unfulfilled expectations of the 'diagnosis' (i.e. a 'creditable consultation') emerged: to be taken seriously, to get time for an informative dialogue, and to achieve an ongoing relationship to the doctor (see Fig. 1).

What did these women do in their efforts to 'deserve' medical attention, and to handle their disappointments? The following strategies recurred in the different women's narratives of how they tried to get complaints and disorders confirmed (see Fig. 2).

A. Strategies to catch the doctor's attention
1. Somatizing. In the effort to be taken seriously, heard and seen, they preferred to present bodily symptoms—manifestations that would be acceptable for the doctor and for themselves:

"I didn't give any details about my private life. Well, I guess I had talked about my bad relationship and so on. I don't suppose you say straight out that you need help. You want it to be something physical."

When no somatic pathology was found they persisted in bodily explanations:

"I was willing to be cut into pieces to figure out what was wrong with me."

2. Claiming under cover. To get access to informations, investigations or therapeutic measures, the women disguised their demands in various ways. They referred to other authorities: "I heard on TV" or "My neighbour, who is a doctor, said", instead of speaking in terms of demands and wishes. Another way to cover up straightforward intentions was by flattering, or by appealing to the doctor's supremacy, and presenting themselves as ignorant of even the simplest facts.

"I was worried about the treatment in the pain clinic. I've heard he is keen on injections. So I called and said: 'I don't understand anything.' I made myself very stupid."

3. Pleading. To cry and beg were described as extreme ways to gain attention, often with success.

"When I was ill I was down on my knees for help. I have been crying my way through the medical service. If I hadn't... no one would have taken care of me... It was thanks to my continual asking."

B. Strategies to uphold self-respect
The strong feelings associated with being rejected made the women search for alternative interpretations of their own and the doctor's behaviour.

4. Mystifying. One way to accept the absence of a creditable diagnosis was to adopt a self-image of being incomprehensible. Therefore the doctor was not to be blamed:

"Nothing works on me. I don't make sense to anybody, because I don't follow any medical laws."

Symptoms were given metaphysical explanations. The aching limbs were ruled by heavenly, meteorological or metallic laws:

"When the snow came, my fingers turned stiff and hard to bend."

5. Martyrizing. Although they described constant pain, and 'pilgrimages' for help to different doctors, they also, conveyed the image of 'silent sufferer', never complaining, 'working beyond' their power:

"For a long time I've thought, it will pass. I'm not the kind who worries much about myself—not until it's too late."

6. Condemning. A forgiving attitude towards the doctor easily turned to one of condemnation. After fruitless encounters they expressed doubts about the doctors' knowledge, interest and authority:

"Well, to be honest, I think that many doctors are terribly ignorant. They know a lot of other things, but the back is just so complicated. There is probably a vast lack of knowledge."

"I'm under a doctor now"
The ultimate position in the search for medical attention was 'to be under a doctor'. Delegating the responsibility to the doctor had its advantages. It implied shelter under a doctor, whose task was to 'keep hold of the patient', her body and her recovery. On the other hand it held women back from taking an active part in their own recoveries.

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**FIGURE 2** Summary of patient experiences, strategies and goals in the consultation
Discussion

On our findings

The aim of this study was to give a voice to non-conforming women patients and to explore their consultation experiences. Experiences of distrust, and strategies to manage health and the health care system, were uncovered. The theme of distrust, based on diagnostic and therapeutic uncertainty, has been recognized by other authors. A lack of identifiable organic causes is reported to set the stage for questions about the legitimacy of the pain, and 'the search for credibility' was a key in another study of women patients suffering from long-term pain.

The patients' strategies can be compared to coping strategies. In a Swedish study, Jensen et al. concluded that women suffering from pain were more inclined than men to use 'catastrophizing' and 'helplessness', classified as maladaptive strategies, strongly related to poor adjustment and unfavourable treatment results. 'I'm under a doctor' at first resembles a coping style relying on 'the powerful other' and implicating an 'external locus of control'. However, one problem with coping theories is the question of causality, and the danger of confounding process and outcome. To see coping strategies as a question of style and personal characteristics is rather static and hides the contextual frames in which they are evolved.

Contextual reflections

How should we understand the grounds for the patients' experiences of distrust, the strategies in the consultation and the agreement of being 'under a doctor'?

The impact of the biological discourse. First, in the participants' narratives, it was obvious how biological considerations drove the diagnostic procedure, and dominated the doctor–patient relationship. When all the investigations have been carried out and been proven of no avail, the two actors' interests begin to diverge. The still suffering patient is somatizing, pleading for and claiming a diagnosis, whereas the doctor is confused about what to do next.

The impact of the asymmetrical doctor–patient relationship. There is a normative pattern whereby the doctor's role is characterized by high status and control; the doctor leads and the patient follows. All the participants described situations where their attempts to question and discuss assumptions were met by correcting, mastering comments such as "that is pure rubbish". Doctors find it problematic to handle distrust and to demonstrate their own weakness. Medical uncertainty and patients having an abrasive behavioural style are perceived as threats by doctors. The doctors' attitudes described by the patients in the study, such as ignoring, disregarding and rejecting, can be seen as the doctor's way to master the threatening position.

In turn these attitudes can intensify the patient's manipulations for attention.

The impact of gender. "Women are just not taken seriously by doctors", was often stated by the participants. It has been shown that women have been disadvantaged in medical research, diagnosis and treatment. The third contextual aspect concerns gender, i.e., the biological sex as well as the socially constructed identity of 'womanliness' and 'manliness'.

The impact of gender on the consultation is not just something that happens but, argues Radley, "serves particular purposes for specific individuals taking part". Women can take advantage of a socially ascribed feminine 'help-seeking behaviour', i.e. to report and discuss feelings and discomfort, and to involve health care in their considerations. Doctors on the other hand might accrue advantages, such as goodwill, status and compliance by inviting female patients into the sick role.

In the light of gender, some of the strategies found, such as pleading, claiming under cover, mystifying and martyring were well suited to a feminine stereotype. So did the position of being 'under' the doctor fit the societal pattern of female subordination.

Under the researching doctor? Reflecting upon context—what happened in the researcher–participants relationship? The researchers (EJ, KH) were women doctors interviewing women patients. The participants expressed satisfaction at having the chance to tell their story to another woman. Still, in the analysis, when studying the interview interaction, situations were revealed where the researcher also took the doctor's role concerning medical knowledge. The participants also admitted that they felt the doctor's positional power to be an obstacle:

"I've always been afraid of doctors. I place them that high, and I am down here. Frankly, I am a little bit afraid of you too. I've been thinking . . . after all . . . why should I expose myself to . . . a complete stranger?"

However, the fact that the limitations of the doctor–patient relationship could be glimpsed also served as an advantage. It made it possible to confirm that the concepts of the analysis—the distrust and the strategies, as well as the contextual frames of biomedicine, power and gender—also emerged in the interview interaction. It was in the researcher–participant interaction that we uncovered how sex stereotypes are present in the doctor–patient interaction: just as the patient role is attached to a 'female' stereotype, the physician role is 'male'. When the participants talked about 'the doctor', they described 'him' as a male stereotype: strong, decisive, but also brusque and rejecting. Their ambiguous perceptions of 'female doctors' were also demonstrated. The participants expected a 'woman' to
be caring, accommodating and understanding, but a
prescribing 'doctor' to be authoritarian and restrictive.

"I'm very glad that you care about my prob-
lems . . . but . . . would you prescribe Valium, if
I asked?"

On our method
The aim of this study was to explore and understand,
not to test a hypothesis or prove causality. Still, validity
problems were thoroughly considered, and procedures
for increasing credibility were conducted.26 In the
analysis, systematic 'codes for the opposite' were used,
such as trying 'admiring' instead of 'condemning'.
Negative cases were searched for: "Were there women
that did not cry and plead?", in order to inhibit
premature conclusions. Of course all women did not
use all the strategies in all consultation situations, but
for every single woman each strategy was present at
least occasionally. The participants' involvement in
the analysing process, through reading their own interview
transcripts and commenting on interpretations, was
accomplished to increase dependability and confirmability.
A group of researchers not involved in the study was
also invited to scrutinize transcripts and codings.

The research setting, in which the interviewers were
family doctors and the interviewees their patients, had
its pros and cons. The prospect of achieving under-
standing and purposeful consequences in future health
care could have encouraged the participants to be open
and frank. The fact that the researchers were women
presumably made it easier for the participants to share
their experiences face-to-face.23 Still, when designing
an open interview study, we expected the women to
tell us more about their expectations and ideas regarding
health care. One might fear that the interviews and the
research design suffer from the same limitations as
revealed in the analysis, i.e. mutual communication
difficulties due to distrust in the biological discourse,
the power asymmetry and the gender impact. Not until
the context was made obvious and discussed could the
women's distrust and manipulative strategies become
comprehensible. The experiences of this interview study
indicate the importance of putting patient, doctor and
their interaction under study. Video-taped consultations
or participating observations might be better research
designs for uncovering contextual interferences.

The study was conducted on a restricted patient group,
20 sick-listed women with undefined MSD. The reader
is advised to keep that in mind when evaluating the
findings. We do not claim that the strategies discovered
are used by all women patients with undefined MSD.
On the other hand they might be recognizable and
transferable to other clinical situations with contextual
resemblance,24 such as in the treatment of undefined
syndromes, in patient education when expertise is
needed in communicating with laymen, and in every-
day situations where gender expectations are disguised.

Conclusions
This study has uncovered the consultation experiences
of a group of women with undefined MSD. The stra-
tegies recognized had no explanatory potential until they
were considered as interactive and variable features in
the consultation context. However, contextual aware-
ness of the interplay between the frames and positions
wherein both the patients and the doctors are acting can
provide opportunities for change. New questions about
how to obtain 'credible consultations' can be broached
for discussion: is 'mutual understanding'—of aetiology,
pathology and treatment—readily attainable in the con-
sultation, when the doctor and patient are unequal in
knowledge, power and gender? We suggest 'negotiated
outcome' to be a better term, placing emphasis on the
gaps between the actors taking part in the medical
encounter.

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References
1 Ong LML, De Haes CJM, Hoos AM, Lammes FB. Doctor-
patient communication: A review of the literature. Soc Sci
2 Pendleton D, Schofield T, Tate P, Havelock P. The consulta-
3 Malterud K. Key questions—A strategy for modifying clinical
communication. Scand J Prim Health Care 1994; 12:
121-127.
4 Stewart MA. What is a successful doctor–patient interview? A
167-175.
5 Skelton AM, Murphy EA, Murphy RLJ, O'Dowd TC. General
practitioner perceptions of low back pain patients. Fam Pract
6 Nachemson A. Newest knowledge of low back pain: A critical
7 Spitzer WO. Low back pain in the workplace: attainable
8 Mathers N, Gask L. Surviving the ‘heartsink’ patients. Fam
9 Arborelius E, Bremberg S, Timpka T. What is going on when
the general practitioner doesn't grasp the situation? Fam Pract
1995; 8: 3-9.
10 Britten N, Jones R, Murphy E, Stacy R. Qualitative research
methods in general practice and primary care. Fam Pract
11 Henrikkson KG. Pathogenesis of fibromyalgia. J Musculo-
skeletal Pain 1993; 1: 3-16.
"I've been crying"


